Montana Rx/Pharmacy Reimbursement Patterns

Reimbursement Basis for Rx, by Montana-based Medical Entity

MT State Workers' Health Plan---Pharmacy PBM			Montana Plan II and Plan III WC Carriers* Average Rx C		Montana Level Medicaid Plan			Current ERD Pharmacy Statute			Draft ERD Pharmacy Administrative Rule		
Brand-name Drugs	Generic Drugs	Dispensing Fee	Brand-name Drugs	Generic Drugs	Brand-name Drugs	Generic Drugs	Dispensing Fee	Brand-name Drugs	Generic Drugs	Dispensing Fee	Brand-name Drugs	Generic Drugs	Dispensing Fee
Retail Pharmacy Pricing: the lower of usual and customary prices or AWP-16%		$1.95 plus co-pay	**Retail Pharmacy Pricing:** AWP-10%		**Retail Pharmacy Pricing:** AWP-15%		$4.70 plus co-pay of $1.00	**Retail Pharmacy Pricing:** AWP		$5.50	**Retail Pharmacy Pricing:** AWP-15%		$3.00
	MAC	$1.95 plus co-pay		MAC or									
	non-MAC minus 16%	$1.95 plus co-pay		AWP-27.5%		AWP-15%	$4.70 plus co-pay of $1.00		AWP	$5.50		AWP-25%	$3.00
Mail Service Pharmacy Pricing: AWP-24%		$0.00	**Mail Service Pharmacy Pri** AWP-15.5%		**Mail Service Pharmacy Pricing:** no separately identified schedule			**Mail Service Pharmacy Pricing:** no separately identified schedule			**Mail Service Pharmacy Pricing:** in-state mail service contracts are encouraged		
	MAC non-Mac minus 24%	$0.00 plus co-pay		MAC or AWP-42.5%									

Dispensing Fee 2.75 2.85

Abbreviations Used:

WC = workers compensation insurance
AWP = Average Wholesale Price
MAC = Maximum Allowable Cost
* = WC insurance entities in Montana known to have Rx PPOs/PBMs
PPO = Preferred Provider Organizations, a contract basis for Rx purchasing
PBMs = Pharmacy Benefit Managers

Issues:

Varying uses of terms, Difficulty of getting to actual Rx cost, Maintaining injured worker access to Rx

Prospective Cost Savings of Draft DLI Pharmacy ARM

$492,000

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24.29.xxxx Payment for prescription drugs---limitations. (1) For payment of prescription drugs, an insurer is liable only for the purchase of generic-name drugs if the generic-name product is the therapeutic equivalent of the brand-name drug prescribed by the physician, unless a generic-name drug is unavailable.

(2) If an injured worker prefers a brand-name drug, the worker may pay directly to the pharmacist the difference in the reimbursement rate between the brand-name drug and the generic-name product, and the pharmacist may bill the insurer only for the reimbursement rate of the generic-name drug.

(3) The pharmacist may bill only for the cost of the generic-name product on a signed itemize billing, except if purchase of the brand-name drug is allowed as provided in subsection (1).

(4) When billing for a brand-name drug, the pharmacist shall certify that the generic-name drug was unavailable.

(5) The reimbursement rate for prescription drugs is based upon the rate in effect on the date the drug is dispensed.

(a) Reimbursement rates to retail pharmacies for brand-name drugs are limited to the average wholesale price (AWP) minus 15 percent of the product at the time of dispensing, plus a dispensing fee, not to exceed $3.00 per product.

(b) Reimbursement rates to retail pharmacies for generic-name drugs are limited to the AWP minus 25 percent of the product at the time of dispensing, plus a dispensing fee, not to exceed $3.00 per product.

(6) The pharmacist may not dispense more than a 30-day supply at any one time.

(7) For the purposes of this section, average wholesale prices must be updated weekly.

(8) For the purposes of this section, the terms "brand name", "drug product", and "generic name" have the same meaning as provided in 37-7-502.

(9) An insurer may not require a worker receiving benefits under this chapter rule to obtain medications from an out-of-state mail order pharmacy. Insurers are encouraged to develop PPO or other contract relationships with retail pharmacies or in-state mail order pharmacies in order to seek even lower drug product costs.

(10) The provisions of this section do not apply to an agreement between a preferred provider organization or managed care organization and an insurer.

(11) Once liability is accepted, the insurer shall reimburse the injured worker for the medical costs paid related to the injury.

24.29.1416 APPLICABILITY OF DATE OF INJURY, DATE OF SERVICE (1) The amounts of the following types of payments are determined according to the specific department rates in effect on the date the medical service is provided, regardless of the date of injury:

(a) medical fees; and

(b) hospital charges.

~~(2) The reimbursement rate for prescription drugs is based upon the rate in effect on the date the drug is dispensed. The rate for a specific generic-name drug is the average wholesale price of that drug plus a reasonable dispensing fee established by the insurer. If the generic drug is unavailable and the pharmacist so certifies under 39-71-727, MCA, the reimbursement rate is the average wholesale price of the brand-name drug plus the dispensing fee.~~

~~(3) Department rates (fee schedules) do not apply to preferred providers or managed care organizations to the extent that they are rendering services or providing goods to workers who are covered by insurers with which they have a contract.~~

~~(4) Pursuant to statute, a pharmacist may not dispense more than a 30 days supply at any one time.~~

24.29.1402 PAYMENT OF MEDICAL CLAIMS (1) Payment of medical claims shall be made in accordance with the schedule of nonhospital medical fees and the hospital rates adopted by the department.

(2) The insurer shall make timely payments of all medical claims for which liability is accepted.

(3) Once liability is accepted, the insurer shall reimburse the injured worker for the medical costs paid related to the injury.

(4) Payment of private room charges shall be made only if ordered by the treating physician.

(5) Special nurses shall be paid only if ordered by the treating physician.

(6) For claims arising before July 1, 1993, no fee or charge shall be payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer.

(7) For claims arising on or after July 1, 1993, no fee or charge other than:

(a) the co-payment provided by 39-71-704, MCA;

(b) the charges for a nonpreferred provider, after notice is given as provided in 39-71-1102, MCA; or

(c) the charges for medical services obtained from other than a managed care organization, once an organization is designated by the insurer as provided in 39-71-1101, MCA, shall be payable by the injured worker for treatment of injuries sustained if liability is accepted by the insurer. The decision whether to require a co-payment rests with the insurer, not the medical provider. If the insurer does not require a co-payment by the worker, the provider may not charge or bill the worker any fee. The insurer must give enough advance notice to known medical providers that it will require co-payments from a worker so that the provider can make arrangements with the worker to collect the co-payment.

Notes:

History: 39-71-727, MCA, was placed in statute 1991. The section below was added in 1993 and became effective 7-1-93.

> (9) An insurer may not require a worker receiving benefits under this chapter to obtain medications from an out-of-state mail service pharmacy.

Additional information for MAPA (2-4-302(1), MCA requirements: a measurement of the number of people impacted by the change and the dollar impact of the change, if known.

Calendar year 2006 total prescriptions issued and paid by Montana State Fund:

MSF portion only prescription count: 99,061
MSF portion only prescription reimbursement total: $7,834,919

(data from Montana State Fund (MSF) database, including 10 year analysis of prescription and other reimbursements ((WW 4/12/07 study, and cf. WW PowerPoint presentation to WCRG in Boston, MA)), percentage times MSF proportion of entire WC industry (48.6%) in Montana in 2005, plus LibertyNorthwest portion ((22.11% of entire MT WC industry market)) projected based on MSF data, and "Calculations for ARM change 24.29.xxxx" of 5/17/07. However, MSF ((largest WC carrier in the state)) has a PBM in place at rates comparable to this draft ARM language, and Liberty Northwest, ((the second largest WC carrier in the state @ 43% of non-MSF market [yr2004])) also has a PBM in place at rates comparable to this draft ARM language, so these WC carriers show the scale but also are excluded from the impacted count and cost projection.)

Projected 2006 total prescriptions issued and paid by <u>entire</u> WC industry:

Total Prescription count: 203,913
Total Prescription reimbursement total: $16,127,869

<u>The Bottom Line Measurement for the ARM Change for year 2006:</u>

A) Number of people (equated to number of prescriptions issued without known PBM or PPO Rx contract, assuming one person per prescription reimbursed) impacted:
59,766

B) Dollar impact of the change (equated to reimbursement cost of prescriptions issued without known PBM, and reduction of dispensing fee from $5.50 to $3.00 per prescription) impacted:

$1,118,446, assuming the balance of the state's WC carriers do not have PPO contracts in place for prescription reimbursement.